DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-8097

April 19, 1979

ALL-COUNTY LETTER NO. 79-22

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: IN-HOME SUPPORTIVE SERVICES NEED ASSESSMENT, NOTICE OF ACTION - APPROVAL AND STATEMENT OF FACTS FORMS

REFERENCE:

Enclosed are copies of several forms that have been revised or newly developed for use in the In-Home Supportive Services (IHSS) Program. These forms are to be utilized to implement the new regulations effective April 1, 1979. These forms are not currently available for counties to order, therefore, you may duplicate the copies attached hereto or reproduce like facsimiles. The forms attached are:

In-Home Supportive Services - Notice of Action - Approval SOC 239C (2/79) replaces SOC 239C (9/78)

*In-Home Supportive Services - Needs Assessment - SOC 293 (3/79) - replaces SOC 293 (9/78) and SOC 293A (9/78)

*In-Home Supportive Services - Statement of Facts SOC 310 (2/79) - New

The following statement will be added to the Needs Assessment and Statement of Facts forms upon final printing:

"Disclosure of social security numbers is mandatory. Our authority to request your social security number is Welfare and Institutions Code 10553. Your social security number will be used to identify you, to match you with other files, and to determine program effectiveness."

It is recommended that this statement either be read to the claimant or added to the SOC 293 and SOC 310 before use.

Training on the new regulations and instruction on use of the above forms was provided to the counties during the month of March. We welcome comments on the forms from the counties. Any necessary changes will be incorporated and a year's supply printed.

Use of these forms is not mandatory at this time, but their use by counties will satisfy regulatory requirements. Counties wishing to use their own forms must obtain approval of the Department. When final versions of these forms are developed, counties will be required to use them or obtain prior Department approval for county substitutes.

JAMES H. GOMEZ
Deputy Director

Enclosure

cc: CWDA

Contact Reference: Program Management Consultant
Adult Services Operations Bureau
744 P Street, M/S 5-100
Sacramento, CA 95814
Telephone (916) 445-8724

STATE OF CALIFORNIA – HEALTH AND WEL RE AGENCY

DEPARTMENT OF SOCIAL SERVICES

IN HOME SUPPORTIVE SERVICES NEEDS ASSESSMENT NEW APPLICATIONS/CHANGES

☐ New Application
☐ Periodic Assessment
☐ Changes

A. RECIPIENT IDENTIFICATION

NAME	CO. CODE	CASE NUMBER	M/C AID CODE	SSN

ADDRESS - NUMBER STREET	IHSS COMPANION CASE(S) NAME(S)

CITY STATE ZIP CODE	ETHNICITY	PHYSICIAN	PHONE
			( )

SPECIAL DIRECTIONS	GUARDIAN/CONSERVATOR	PHONE
		( )

BIRTHDATE, MO DAY YR.	SEX	PRIMARY LANGUAGE	PHONE	EMERGENCY CONTACT	PHONE
					( )

B. DATE OF HOME VISIT:

SERVICES DIRECTED TO GOAL NO.

C. SOCIAL WORKERS ASSESSMENT OF PHYSICAL AND MENTAL STATUS OF RECIPIENT

1. Ability to perform *(Check)*

	GOOD	FAIR	POOR
Standing			
Reaching			
Lifting			
Walking			
Bending			
Eating			
Endurance			

2. Effect of Recipient's Mental Status on Ability to Perform Tasks

3. Special Conditions (Diet, Mobility, Prescribed Medication, etc.)

4. Recipient's Statement of Need

5. Comments

D. RECIPIENT LIVING ARRANGEMENTS

1. Recipient lives in:
☐ House ☐ Mobile Home ☐ Other
☐ Apartment ☐ Hotel

2. No. of rooms

3. Are facilities in home?
Laundry ☐ YES ☐ NO
Cooking ☐ YES ☐ NO

4. Special conditions in living arrangements:

5. Other persons in household: NAME	AGE	RELATIONSHIP	Rec. IHSS Yes	Rec. IHSS No	HRS. AT WORK/ IN SCHOOL	LIMITATIONS WHICH PREVENT PROVISION OF IHSS TO RECIPIENT

E. HEAVY CLEANING

Total House Needed	_____ per instance (MPP 30-463.22)
Adjustments	_____ hr. per instance (MPP 30-463.23-.25)
Alternative Resources (list in G on reverse side)	_____ hr. per instance (MPP 30-463.3)
To be Provided by IHSS	_____ hr. per instance (MPP 30-463.4)
Unmet Need	_____ hr. per instance (MPP 30-461.274)

Is heavy cleaning needed more than once per year? ☐ YES ☐ NO If YES, justify per MPP (30-457.22 or .23)

Was heavy cleaning provided during the last authorized period? ☐ YES ☐ NO

Should heavy cleaning be provided during the current authorized period? ☐ YES ☐ NO

F. SERVICES (Hours per week)	TOTAL Need	Adjust-ments	TOTAL Need for IHSS	Alternative Resources	To be pur-chased by IHSS	Unmet Need
1. DOMESTIC SERVICES						
a. Sweeping, vacuuming, etc.						
b. Washing kitchen counters, etc.						
c. Cleaning bathroom						
d. Storing food and supplies						
e. Taking out garbage						
f. Dusting and picking up						
g. Cleaning oven and stove						
h. Cleaning and defrosting refrigerator						
i. Bringing in fuel and miscellaneous						
2. RELATED SERVICES						
a. *Preparation of meals						
b. Meal clean up and menus						
c. Routine mending and laundry, etc.						
d. Changing bed linen and making bed						
e. Shopping for food						
f. Other shopping and errands						
3. NON-MEDICAL PERSONAL SERVICES						
a. *Respiration						
b. *Bowel and bladder care						
c. *Feeding						
d. *Routine bed baths						
e. *Dressing						
f. *Menstrual care						
g. *Ambulation						
h. *Moving into and out of bed						
i. Bathing, oral hygiene and grooming						
j. Rubbing skin, etc.						
k. Care and assistance with prothesis						
4. TRANSPORTATION SERVICES						
a. Medical appointment						
b. To alternative resources						
5. YARD HAZARD ABATEMENT						
6. NON-MEDICAL PROTECTIVE SUPERVISION						
7. TEACHING AND DEMONSTRATION						
8. TOTAL "TO BE PURCHASED BY IHSS" COLUMN						
9. Does recipient opt for restaurant meal allowance? ☐ YES ☐ NO If YES, add total hours from line 2a, b, c.						
10. SUBTRACT LINE 9 FROM LINE 8						
11. MULTIPLY LINE 10 TIMES 4.33 = HOURS PER MONTH.						

G. ALTERNATE RESOURCES – 1. Needs provided by others:

SOURCE	SERVICE

2. Is the recipient receiving in-home care through medi-cal? ☐ YES ☐ NO If YES...

TYPE	EXPECTED DURATION

3. If no alternate resources used, why not?

H. PROVIDER

1. Is recipient able to supervise provider and give directions for household and personal care needs? ☐ YES ☐ NO If NO, who will supervise provider?

2. Does recipient need assistance in obtaining a provider? ☐ YES ☐ NO If YES, action taken by county:

3. Service delivery method to be utilized if service is authorized : ☐ County Provider ☐ Individual Provider ☐ Contract Agency

4. Immediate Outcome without IHSS		5. Check (✓)	
Remain In Home		Severely Impaired	
Board and Care			
SNF/ICF		Non-severely Impaired	
Acute Hospital			

I. RECOMMENDATION

The recommended amount of hours authorized per month for IHSS are _____. The period of service authorization is effective / / to / /

SOCIAL WORKER	DATE	APPROVED BY	DATE

STATEMENT OF FACTS FOR IN-HOME SUPPORTIVE SERVICES

INSTRUCTIONS: Your eligibility will be decided on the information you give on this form. Using ink, complete all items. Please print.

1. APPLICANT'S NAME (FIRST, MIDDLE, LAST)	BIRTHDATE	FOR COUNTY VERIFICATION USE ONLY
HOME ADDRESS (STREET, CITY, ZIP)		
MAILING ADDRESS (IF DIFFERENT)	HOME PHONE	MESSAGE PHONE
PLACE OF BIRTH	SOCIAL SECURITY NUMBER	RETIREMENT CLAIM NUMBER

ARE YOU?

☐ OVER 65 ☐ DISABLED ☐ BLIND

MARITAL STATUS — DATE

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

2. SPOUSE'S NAME	BIRTHDATE
SOCIAL SECURITY NUMBER	RETIREMENT CLAIM NUMBER

IS SPOUSE?

☐ OVER 65 ☐ DISABLED ☐ BLIND

3. DO YOU INTEND TO RESIDE IN CALIFORNIA? ☐ YES ☐ NO

4. ARE YOU A UNITED STATES CITIZEN? ☐ YES ☐ NO

IS SPOUSE A UNITED STATES CITIZEN? ☐ YES ☐ NO

5. ARE THERE OTHERS LIVING IN THE HOUSEHOLD? ☐ YES ☐ NO
If yes, give the information below.

NAMES	RELATIONSHIP

6. LIVING ARRANGEMENT

☐ I live in a home I am buying or own.

☐ I rent a room, apartment or house.

☐ I pay for room and board.

☐ I receive free room and board.

☐ I live in and own, or I am buying a trailer, boat or motorhome.

DESCRIPTION

ESTIMATED VALUE

$

FOR COUNTY VERIFICATION USE ONLY

7. DO YOU OWN REAL PROPERTY OTHER THAN YOUR HOME?

If yes, give the information below. ☐ YES ☐ NO

ADDRESS (STREET, CITY, ZIP)			
ASSESSED VALUE $	AMOUNT OWED $	PARCEL NUMBER	MONTHLY PAYMENT $
MONTHLY INCOME $	ANNUAL ASSESSMENTS $	ANNUAL TAXES $	ANNUAL INSURANCE $
TAXES INCLUDED IN MONTHLY PAYMENT? ☐ YES ☐ NO		INSURANCE INCLUDED IN MONTHLY PAYMENT? ☐ YES ☐ NO	
OTHER PROPERTY EXPENSES			

8. WHAT IS THE VALUE OF YOUR OTHER ASSETS?

DO YOU HAVE?	CHECK IF NONE	ENTER VALUE UNDER OWNER		
		Applicant	Spouse	Both
a. Money in the house		$	$	$
b. Checking account				
c. Savings account, credit union, trust funds				
d. Checks or cash in safety deposit box				
e. Stocks or bonds (market value)				
f. Notes, mortgages, deeds, contracts (market value)				

9. DO YOU HAVE LIFE INSURANCE POLICIES? ☐ YES ☐ NO

If yes give the information below.

	INSURANCE COMPANY	PERSON INSURED	POLICY OWNED BY	FACE VALUE	POLICY NUMBER	DATE ISSUED	SURR. CASH VAL.
a.							
b.							
c.							
d.							

10. DO YOU HAVE ANY IRREVOCABLE BURIAL TRUSTS? ☐ YES ☐ NO

If yes, give the information below.

NAME OF COMPANY	PURCHASE PRICE $	FOR WHOM?

11. DO YOU OWN MOTOR VEHICLES (cars, trucks, motorcycles, boats, campers, trailers)? If yes, give the information below. ☐ YES ☐ NO

MAKE	MODEL	YEAR	Last License Fee Pd.		AMOUNT OWED	Check If Used For	
			Date	Amount		Work	Medical Transp.

FOR COUNTY VERIFICATION USE ONLY

12. ARE YOU OR YOUR SPOUSE EMPLOYED (Include self-employed)? ☐ YES ☐ NO

If yes, give the information below.

NAME OF EMPLOYER	HOW OFTEN PAID?	GROSS SALARY PER PAY PERIOD
		$
ADDRESS		OCCUPATION

13. DO YOU RECEIVE IN-KIND INCOME? ☐ YES ☐ NO

If yes, give the information below.

TYPE

FREQUENCY

14. IF YOU ARE APPLYING AS BLIND, DO YOU HAVE ANY WORK RELATED EXPENSES DUE TO BLINDNESS? Such as:

SPECIAL TRANSPORTATION COST:	INCREASED HOUSEHOLD MAINTENANCE COST:

ITEMS OR SERVICES NEEDED FOR JOB PERFORMANCE COST:

15. LIST INCOME RECEIVED EACH MONTH OTHER THAN EMPLOYMENT

TYPE OF INCOME	CHECK IF NONE	ENTER AMOUNT RECEIVED BY		
		Applicant	Spouse	Both
a. Unemployment Insurance		$	$	$
b. Disability Insurance				
c. Veteran's Pension				
d. Railroad Pension				
e. Social Security				
f. Civil Service				
g. Other retirement pension				
h. Alimony (Spousal support)				
i. Payment for room and board				
j. Rents, dividends, royalties				
k. Contributions or gifts				
l. Workers' Compensation				
m. Other				
n. AFDC payments				

16. HAVE YOU APPLIED FOR OR DO YOU EXPECT TO RECEIVE DURING THE NEXT 6 MONTHS ANY OF THE BENEFITS LISTED IN ITEM 16? ☐ YES ☐ NO

If yes, give the information below.

TYPE OF INCOME	DATE APPLIED	PLACE APPLIED
a.		
b.		
c.		

17. ARE YOU INTERESTED IN TALKING TO A SOCIAL WORKER ABOUT OTHER SERVICES WHICH MAY BE AVAILABLE. If yes, explain. ☐ YES ☐ NO

FOR COUNTY VERIFICATION USE ONLY

18. ADDITIONAL INFORMATION (Give item number. Attach additional sheet, if needed.)

ITEM NUMBER	

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING.

- I hereby state by my signature that the answers I have given are correct and true to the best of my knowledge.
- I agree to tell the County Welfare Department within 10 DAYS if there are any changes in my income, possessions or expenses or in the number of persons in my household, or if any change of address, and I agree to meet all other responsibilities explained in the "Medi-Cal Responsibilities Checklist" I have received.
- I understand that I may be asked to prove my statements, but that the county is required by law to keep them confidential.
- I understand that if I am dissatisfied with actions taken by the County Welfare Department, I have the right to a fair hearing.

I UNDERSTAND THAT THE INFORMATION I PUT ON THIS FORM MAY BE VERIFIED AND THAT MY SIGNATURE ON THIS FORM IS AN AUTHORIZATION FOR SUCH AN INVESTIGATION.

I, the undersigned, declare under penalty of perjury that the foregoing statements are true and correct.

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF PERSON ACTING FOR APPLICANT — RELATIONSHIP (GUARDIAN, CONSERVATOR, ETC.)	DATE
SIGNATURE OF WITNESS (REQUIRED IF APPLICANT SIGNED BY MARK)	DATE
SIGNATURE OF PERSON HELPING APPLICANT COMPLETE FORM	DATE

State of California—Health and Welfare Agency

Department of Social Services

SOCIAL SERVICES

IN–HOME SUPPORTIVE SERVICES

NOTICE OF ACTION

APPROVAL

(County Stamp)

Case Number _____

Date Mailed _____

KEEP THIS FORM WITH YOUR IMPORTANT PAPERS

The items that are checked apply to you:

☐ You are eligible to receive In-Home Supportive Services beginning _____ (Date).

☐ You are eligible to receive In-Home Supportive Services beginning _____ (Date), but you must pay for the first $ _____ of the services you receive. The amount you must pay was determined as follows:

Your income that was counted	$ _____
SSI/SSP benefit level	– $ _____
Share of cost	$ _____

☐ See attachment for a list of services authorized and the hours.

☐ Services authorized ☐ per month ☐ per week:

	Hours
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

☐ Total hours authorized per month _____.

☐ Total dollars authorized per month $ _____.

☐ You must make the following deductions on behalf of your provider:

☐ Additional deductions from authorized monthly amount:

☐ You are severely impaired. As a severely impaired person you have the right to receive an advance payment so that you can hire your own provider. If you want to receive this advance payment, contact your social worker.

You must report immediately any changes that might change your eligibility or need for In-Home Supportive Services. If you have any questions or think additional facts should be considered, please contact:

_____ Social Worker

_____ Telephone

PLEASE READ REVERSE SIDE FOR IMPORTANT

INFORMATION ABOUT YOUR RIGHT TO A FAIR HEARING

DO NOT CUT OR TEAR — SEND ENTIRE PAGE

RIGHT TO REQUEST A STATE HEARING

1. You have the right to a conference with representatives of the county social services department to talk about this intended action. At such a conference, you may speak for yourself or be represented by a lawyer, a friend or other spokesman. If you want a conference, contact your county department.

2. Whether you request a conference or not, you also have the right to request a State Hearing and decision by the Director of the State Department of Social Services (see form below). Your request may be written or oral but it must state that you want a hearing and why you are dissatisfied. Your request for a hearing must be made within one year of the date of this notice.

3. IF YOU MAIL YOUR REQUEST FOR A HEARING WITHIN 10 DAYS OF THE DATE OF THIS NOTICE, YOUR SERVICES MAY CONTINUE UNTIL THE HEARING. You will not be liable for repayment of services monies received pending the hearing, even if the result is a denial, provided your request is made in good faith.

4. You may request a State Hearing on your own, or you may ask your county department for assistance. In either case, however, be sure to inform your county department worker as soon as possible.

5. At a State Hearing you have the right to be represented by an attorney or any other person (a friend, relative, or other spokesman), of your choice. You may obtain free legal advice and the services of a lawyer by contacting the nearest legal services office. You may also contact the nearest social service rights organization for assistance in presenting your claim. If free legal representation is available locally, the telephone number and/or address is listed below.

_____

_____

6. State regulations governing State Hearings for social services are available at this office of the county social services department.

7. Information Practices — The information you are requested to provide is mandatory in order to process your request for a State Hearing pursuant to W&IC 10950. A case file will be established by the Office of the Chief Referee. You have the right to examine the materials that constitute the record for decision. Any information you provide may be shared with the county social services department or the United States Departments of Health, Education and Welfare.

If you wish to make a **written** *request for a State Hearing, please send this page to:*

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 19-36
Sacramento, CA 95814

To make an **oral** *request for a State Hearing or further information about your State Hearing rights or files you may contact:*

Chief
Public Inquiry and Response
State Department of Social Services
(800) 952-5253 (toll-free number)

DO NOT CUT OR TEAR — SEND ENTIRE PAGE

REQUEST FOR STATE HEARING

NAME (LAST, FIRST, MIDDLE INITIAL)	PHONE NO. ( )	SOCIAL SECURITY NO.

ADDRESS	CITY	STATE	ZIP CODE

I hereby request a State Hearing before the State Department of Social Services from the action taken by the County regarding my application for social services. The reasons for my request are as follows:

_____

_____

_____

I have trouble understanding English, therefore I request an interpreter for my hearing in the following:	LANGUAGE	DIALECT

SIGNATURE	DATE SIGNED

AUTHORIZED REPRESENTATIVE

I have authorized the following person to act on my behalf in my appeal. I authorize the Department to release any or all information about my case to that person.

NAME OF AUTHORIZED REPRESENTATIVE

ADDRESS OF AUTHORIZED REPRESENTATIVE

SIGNATURE OF STATE HEARING APPLICANT	DATE SIGNED